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Listen, understand, collaborate: developing innovative strategies to improve health service utilisation by Aboriginal and Torres Strait Islander men

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There's been enough talk, now is the time for action. Primary health care services (PHCSs) need to collaborate and develop innovative strategies to increase the use of health services by Aboriginal and Torres Strait Islander men. Currently, Aboriginal and Torres Strait Islander men are viewed as being disinterested in their health, thus, the blame is being placed on the individuals themselves for their under-utilisation of PHCSs. In contrast to this misconception, studies have found that Aboriginal and Torres Strait Islander men are interested in their health but many face significant barriers that hinder access.[1-7] In response, Aboriginal and Torres Strait Islander men have identified strategies for PHCSs to reduce barriers and increase their use, which fundamentally includes working with local men to develop innovative strategies.[1,5-7]

Aboriginal and Torres Strait Islander men are frequently described as having the worst health and social statistics in Australia. The life expectancy gap[8] and burden of disease[9] remains unacceptably high. The ill health of Aboriginal and Torres Strait Islander men is demonstrable across virtually all measures of mortality and morbidity;[10] this group also experiences high rates of suicide, homelessness, unemployment and imprisonment, all of which contribute directly and indirectly to ill health and many other markers of wellbeing.[11]

Unfortunately, the commentary that often accompanies these statistics remains largely negative and either explicitly or implicitly places blame and personal responsibility for ill health and social disadvantage on the lifestyle 'choices' of these men.[12-14] Such blame is unhelpful, unwarranted and – in some cases – directly harmful. It is also often a result of an ideological position that seeks to place the onus of people's own misfortunes on themselves, thus, ignoring the pervasive effects of disadvantage, inequality and structural racism on illness and its determinants. In addition, racism continues to shape Australian policies, laws and community perceptions, and plays an equally pivotal role in framing the social determinants of health for Aboriginal and Torres Strait Islander people.[12]

The causes of male health disadvantage are both complex and interwoven. Marmot[15] suggested poverty and inequality are largely responsible for the significant life expectancy deficit faced by Aboriginal and Torres Strait Islander people; however, the social determinants, which play a significant part in the ill health of these same men, are but one facet in addition to a litany of other contributing factors that must urgently be addressed.

Health seeking

Generally, Australian men are considered reluctant to seek help for their own health issues. As Smith et al. explained, "it is commonly held that men delay help seeking because they are ignorant about and disinterested in their health".[16(p1)] Such generalisations hide important contextual and more complete understandings of the reasons for poor healthcare use and rarely include the laymen's perspectives relating to men's help-seeking practices.[16] Indeed, the lack of men's voices is also consistent within discussions of Aboriginal and Torres Strait Islander men and their under-utilisation of health services.

The available data detailing Aboriginal and Torres Strait Islander health service use is patchy[17,18]; however, most indicates that Aboriginal and Torres Strait Islander men use PHCSs at lower rates than their female counterparts, especially for preventative healthcare. Many authors suggest Aboriginal and Torres Strait Islander men tend to delay care, often presenting at a time of advanced or serious illness.[1,10,11,19] Yet, access and utilisation are a function of multiple, complex and interacting factors that enable (or inhibit) Aboriginal and Torres Strait Islander men from accessing and using available care. These issues may include a lack of continuity of care, cultural factors pertaining to communication and understanding, counteracting social pressures, and both self-determination and control. Essentially, as Hayman et al. observed, part of the problem derives in the fact that "Aboriginal and Torres Strait Islander people are not sufficiently involved in planning, delivering and evaluating relevant healthcare services".[20(p485)]

The perception that Aboriginal and Torres Strait Islander men are both disinterested in and reluctant to engage with their health is a common assumption, which, perhaps, stems from little being done to listen to and learn from their perspectives. Others, such as Brown et al. instead posit that Aboriginal and Torres Strait Islander men are very interested in their health and wish to engage with primary and other healthcare services, yet are rarely consulted on what they seek and how services can better meet their needs, and seldom informed about alternate approaches to healthcare access and use.[21] Herein lies the enormous challenge facing services and policy makers alike.

Health service utilisation is critical, as access to and appropriate use of comprehensive and high-quality PHCSs can have a significant effect in the health and wellbeing of marginalised and disadvantaged populations.[22-24] PHCSs and key stakeholders must first understand the reasons surrounding this phenomenon of under-utilisation, although identifying the barriers faced is simply not enough. Health services must be willing and able to make

the necessary changes to improve access, evaluate their strategies, share their findings and improve continuity of care. A fully committed, reliable and sustained approach is essential, as band-aid solutions will not and have not worked.

Barriers

The barriers to health service use for Aboriginal and Torres Strait Islander people were explored in the 2014–2015 Aboriginal and Torres Strait Islander Health Survey conducted by the Department of the Prime Minister and Cabinet.[19] This review found that 35% of respondents believed they had been treated unfairly within the previous 12 months because they were an Aboriginal or Torres Strait Islander person. Of those, 13% reported they had avoided seeking healthcare due to experiencing unfair treatment in the past.[19]

The participants in three additional studies exploring the barriers and enablers for primary healthcare access faced by Indigenous men all felt health services and staff needed to be more culturally appropriate, while many also thought they lacked information regarding services available at primary health care centres.[1,3,25] Additional barriers included distrust and fear of health services, as well as shame and stigma around sensitive health issues. This highlighted the importance of safe and supportive spaces for Aboriginal and Torres Strait Islander men especially when dealing with sensitive health, social and cultural concerns, an issue previously raised by community-based Indigenous researchers.[26]

Gender-specific services can certainly play another major role in establishing and sustaining accessible and culturally appropriate care.[1,5,7,27] For example, the well-established Aboriginal community-controlled organisation Danila Dilba Health Service in Darwin demonstrates that gender-specific healthcare services are both a viable and highly accessed service.[27] In addition, PHCSs can increase their cultural appropriateness by employing male health practitioners, offering choices to clients regarding the gender of their practitioner and holding men's-only clinic days or times when men can visit these facilities and communicate with male staff for all their health needs.

Insufficient healthcare resourcing contributes towards the under-use of PHCSs for Aboriginal and Torres Strait Islander people. In 2009, the National Health and Hospitals Reform Commission recommended an investment strategy for Aboriginal and Torres Strait Islander people's health, stating this investment should be "proportionate to health need[s], the cost of service delivery, and the achievement of desired outcomes. This requires a substantial increase on current expenditure".[28(p20)] Despite this, the 2014–2015 Australian Federal Budget saw aggressive budget cuts to Aboriginal and Torres Strait Islander affairs and health, particularly preventative healthcare, which has significantly affected the extent to which health services can provide them necessary amenities.[29]

Improving health services will not be the only change required to close the life expectancy gap, as systemic problems of social and economic disparity, discrimination and a lack of empowerment exist. To address this health crisis, changes in economic policy, improvements in education for Aboriginal and Torres Strait Islander males, access to sport and recreation facilities and programs, development of sustainable employment opportunities, a commitment to cultural maintenance, improved engagement with correctional services as well as increased health awareness are all needed. Essentially, addressing healthcare in isolation from sociocultural and economic factors will only ever have a limited effect. Notably, the 2016 Close the Gap Progress and Priorities report outlined many recommendations including: the introduction of 'Closing the Gap Targets' to reduce imprisonment; increasing focus on the needs of Aboriginal and Torres Strait Islander people with disabilities; a national inquiry into racism and institutional racism in healthcare; and a reform of the Indigenous Advancement Strategy.[30]

Despite the many barriers, Aboriginal and Torres Strait Islander men are putting up their hands in a collective show of need[1,5,11] to encourage change and to be responsible for leading the way in the fight to turn around generations of disadvantage.

Looking forward

As Marmot suggested, "wider social policy will be crucial to reduction of inequalities in health".[15(p1103)] The development of male health policy must rely on the strengths that already exist within Aboriginal and Torres Strait Islander men and communities, rather than the deficit approach that is currently favoured to frame Aboriginal and Torres Strait Islander health and policy. Building on these strengths should be the cornerstone of future health and development, and an essential investment in the future generations of Aboriginal and Torres Strait Islander people.

A recent systematic review of primary healthcare interventions for Indigenous people with chronic disease highlighted five key enablers and inhibiting factors for program development to affect "upon intervention implementation and/or sustainability within a [primary health care] setting".[31(p9)] These included design attributes, workforces, the importance of patient-provider partnerships, the adequate development of clinical pathways and mechanisms to improve access to services. Essentially, these findings should be considered when attempting to implement strategies specific to the needs of Aboriginal and Torres Strait Islander men.

The time has come to collaborate and share knowledge and experiences, to put aside individual egos and to be honest – even about our collective failures to adequately and purposefully engage men. Findings need to be published, including unsuccessful programs, to help others learn from past experiences. We need to stop describing problems and blaming individuals, and start acknowledging Aboriginal and Torres Strait Islander men as the dynamic, essential elements of families, communities and societies they have always been.[32] The inherent personal and cultural strengths and attributes of Aboriginal and Torres Strait Islander men must be unshackled, and positive energy directed towards the development of new ways forward by men and their communities, who are empowered and supported to do so.

Funding alone will not close the life expectancy gap. PHCSs can have the latest technology in purpose-built centres, employ some of the best staff available, and provide a plethora of programs, but all of this remains ineffective if the men themselves choose not to use them. In the Torres Strait Islands, there is an expression derived from traditional dance called 'mark time', which refers to a dancer stepping in beat with the music while remaining on the spot. Although you are moving, you are also going nowhere. Likewise, PHCSs and key stakeholders need to urgently rethink the future direction of engaging Aboriginal and Torres Strait Islander men and must no longer simply 'mark time'.

Short-term funding is also problematic. It is common for programs or interventions implemented by PHCSs to cease due to funding cuts, despite their outcomes. In fact, as O'Dea explained, "the challenge is to sustain these interventions over the long term in the frequently under-resourced primary health care clinics".[33(p5)] Services also have to manage the fallout from defunded programs which includes the loss of engagement, rapport and trust with local Aboriginal and Torres Strait Islander men, not to mention the subsequent turnover of staff that affects continuity of care. Despite the issues of funding, which is often outside of the control of PHCSs, prioritising engagement with local Aboriginal and Torres Strait Islander men (and the broader community) is essential. Engagement is a low-cost exercise for most PHCSs, with the exception of some remote services or those currently severely under-resourced, but it does require a change of attitude.

Aboriginal and Torres Strait Islander men hold the key to their future, as they know what they need and what will get them through the doors. These men need – and want – to take their health in their own hands; however, it is unrealistic to expect them to improve their current situation alone. Proper engagement with and commitment to Aboriginal and Torres Strait Islander men's health is a logical first step for PHCSs. Ultimately, a collaborative effort from researchers, PHCSs, peak health bodies and government is required to empower Aboriginal and Torres Strait Islander men and their communities to develop and implement new engagement strategies. Sadly, if this is not the case, closing the life expectancy gap will remain nothing more than an advertising slogan.

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